

Medical Assistance Administration



Home Health Services

(Acute Care Services)

Billing Instructions

September 2002

(WAC 388-551-2000 through 2220)

About this publication

This publication supersedes all previous MAA Home Health Services Billing Instructions and Numbered Memorandum 02-52 MAA.

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Washington State Department of Social and Health Services
September 2002

The following MAA programs have their own billing instructions which may be obtained from the MAA Division of Program Support (see address listed in Important Contacts section). You must bill for any equipment and/or services related to these programs using their specific billing instructions.

Blood Bank	Maternity Support Services
Chiropractic Services for Children	Medical Nutrition
Durable Medical Equipment & Supplies	Medical Nutrition Therapy
Early Periodic Screening, Diagnosis & Treatment (EPSDT)	Neurodevelopmental Centers
Hospice	Nondurable Medical Supplies & Equipment
Home Infusion/Parenteral Therapy	Nurse Delegation Services
Maternity Case Management	Private Duty Nursing for Children

To obtain copies of MAA's Billing Instructions or Numbered Memorandum:

Check out our web site:

<http://maa.dshs.wa.gov>

-OR-

Write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Received too many billing instructions?

Too few?

Address Incorrect?

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.
[WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9246
Olympia WA 98507-9246

Magnetic Tapes/Floppy Disks:
Division of Program Support
PO Box 45560
Olympia, WA 98504-5560

Electronic Billing?
Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
(360) 725-1267

Where should I send medical verification of visits, Plan of Care, and Change Orders during Focused Review Period?

Quality Fee-For-Service
Home Health Program Manager
PO Box 45506
Olympia WA 98504-5506

Who do I call to get a list of Interpreter Agencies in my area?

(800) 562-6188 or go to:
<http://maa.dshs.wa.gov> (Numbered Memos link, Year 2001, **01-01 MAA**)

Where do I call if I have questions regarding...

Home health policy or medical review questions?

Home Health Program Coverage
Home Health Program Manager
(360) 725-1676
(360) 586-2262 FAX

Long-term care (LTC) needs?

Home Health needing LTC Exceptions
(360) 725-1582

Home and Community Services

(HCS) Front of local telephone book **or call:** State Reception Line 1-800-422-3263 and ask for local HCS number.

Division of Developmental Disabilities (DDD)

Region 1 (800) 462-0624
Region 2 (800) 822-7840
Region 3 (800) 788-2053
Region 4 (800) 314-3296
Region 5 (800) 248-0949
Region 6 (800) 339-8227

Pharmacy Authorization?

Pharmacists Only (800) 848-2842

Important Contacts (cont.)

Where do I call if I have questions regarding...

Payments, denials, billing questions, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at:

<http://maa.dshs.wa.gov>

[Click on "Provider Publications/
Fee Schedules," Click "Accept,"
then go to "Billing Instructions.]"

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Acute care – Care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.
[WAC 388-551-2010]

Authorization - Official approval for department action.

Authorized Practitioner – An individual authorized to sign a home health plan of care.

Brief Skilled Nursing Visit – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

- An injection;
- Blood draw; or
- Placement of medications in containers.

[WAC 388-551-2010]

Case Manager – A social worker or a nurse assigned by the Department of Social & Health Services (DSHS), Aging and Adult Services Administration (AASA) to manage and coordinate the client's case.

Case Resource Manager (CRM) - An individual who meets with the family and assesses the client's DDD needs, develops a plan with the family and helps connect to appropriate resources assigned by the Division of Developmental Disabilities (DDD).

Chronic care – Long-term care for medically stable clients.
[WAC 388-551-2010]

Client – Any individual who has been determined eligible to receive medical or health care services under any medical assistance program.

Department - The state Department of Social and Health Services.
[WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Full skilled nursing services – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

- Observation;
- Assessment;
- Treatment;
- Teaching;
- Training;
- Management; and
- Evaluation.

[WAC 388-551-2010]

Healthy Options - See Managed Care.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence.
[WAC 388-551-2010]

Home Health Aide – An individual registered or certified as a nursing assistance under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both. [WAC 388-551-2010]

Home Health Aide services – Services provided by a home health aide when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by, or under contract with, a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners, and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's conditions and needs, and completing appropriate records.
[WAC 388-551-2010]

Home Health skilled services – Skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a Medicare certified home health agency with a current MAA provider number. [WAC 388-551-2010]

Long-term care – A generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the department's Aging and Adult Services Administration (AASA) or Division of Developmental Disabilities (DDD). [WAC 388-551-2010]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320.
[WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within the department of social and health services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification (ID) card – The form the Department of Social and Health Services uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Plan of Care (POC) – (Also known as “plan of treatment” [POT]). A written document that is established and periodically reviewed and signed by both a physician and a home health agency provider. The plan describes the home health care to be provided at the client’s residence.
[WAC 388-551-2010]

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Disease Case Management;
- Family Planning Services;
- First Steps;
- Field Services;
- Managed Care Contracts; and
- Provider Relations.

Provider or Provider of Service - An institution, agency, or person:

- a) Who has a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- b) Is eligible to receive payment from the department. [WAC 388-500-0005]

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Residence - A client's home or private place of living. [WAC 388-551-2010]
(See page D.1 & D.8 for information on clients in residential facilities whose home health services are not covered through MAA's home health program.)

Review Period – The three-month period MAA assigns to a home health agency, based on the address of the agency's main office, during which MAA reviews all claims submitted by that agency.
[WAC 388-551-2010]

Revised Code of Washington (RCW) - Washington State laws.

Specialized therapy – Skilled therapy services provided to clients that include: physical, occupational, and speech/audiology services. [WAC 388-551-2010]

Supervision - Authoritative procedural guidance given by a qualified person who assumes the responsibility for the accomplishment of a function or activity and who provides initial direction and periodic inspection of the actual act of accomplishing the function or activity.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.
[42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual & Customary Fee – The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

Home Health Services

What is the purpose of the Home Health Program?

[Refer to WAC 388-551-2000]

The purpose of the Medical Assistance Administration (MAA) home health program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in the client's residence when the client is not able to access the medically necessary services in the community.

Home health skilled services are provided for **acute**, intermittent, short-term, and intensive courses of treatment.



Note: Chronic, long-term maintenance care - See page D.7.

Who is an eligible home health provider?

[Refer to WAC 388-551-2200]

The following may contract with MAA to provide health services through the home health program, subject to the restrictions or limitations in this billing instruction and applicable published Washington Administrative Code (WAC).

A home health agency that:

- Is Title XVIII (Medicare) certified;
- Is Department of Health (DOH) licensed as a home health agency;
- Continues to meet DOH requirements;
- Submits a completed, signed Core Provider Agreement to MAA; and
- Is assigned a Home Health provider number.

A registered nurse (RN) who:

- Is prior authorized by MAA to provider intermittent nursing services when no home health agency exists in the area a client resides;
- Is unable to contract with a Medicare-certified home health agency;
- Submits a completed, signed Core Provider Agreement to MAA; and
- Is assigned a provider number.



Important! Please notify MAA at 1-866-545-0544 within ten days of any change in name, address, or telephone number.

Notifying clients of their rights (advance directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions. Keep a copy of the written information in the client's record.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who is eligible? [Refer to WAC 388-551-2020(1)]

Clients with the following medical program identifiers on their DSHS Medical Identification (ID) cards are eligible to receive home health services subject to the limitation described in these billing instructions:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program The following clients are eligible for Home Health services and are identified by the CNP identifier on their DSHS Medical ID cards: <ul style="list-style-type: none"> ✓ General Assistance – Expedited – GAX (disability determination pending) clients; and ✓ Pregnant Undocumented Alien
CNP – Children’s Health	Categorically Needy Program – Children’s Health <i>Clients with this identifier on their Medical ID card are <u>not eligible</u> for this, or any Medical Assistance Program, after 9/30/02.</i>
CNP – CHIP	CNP – Children’s Health Insurance Program
GAU No Out of State Care	General Assistance Unemployable
General Assistance – No Out of State Care	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program-Medically Needy Program



Note: Please refer clients to their local Community Services Office (CSO) if they need Home Health services and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive Home Health Services.

Restrictions [Refer to WAC 388-551-2020(2)]

MAA does not cover home health services under the home health program for clients with one of the following medical program identifiers on their Medical ID cards. However, MAA does evaluate requests for home health skilled nursing visits on a case-by-case basis for clients with “**Emergency Medical Only**” listed on their Medical ID and may cover up to two skilled nursing visits within the eligibility enrollment period. Refer to page D.9 to further information.

- **CNP - Emergency Medical Only**; and
- **LCP-MNP – Emergency Medical Only**

MAA does not cover home health services under the home health program for clients whose Medical ID card lists **MIP-EMER Hospital Only – No out-of-state care** (Medically Indigent Program) are not eligible for Home Health services.

Managed Care Clients [Refer to WAC 388-551-2020(1)]

Clients with an identifier in the HMO column on their DSHS Medical ID cards are enrolled in one of MAA’s Healthy Options managed care plans. Clients enrolled in a Healthy Options managed care plan receive all home health services through their designated plan, subject to the plans’ coverages and limitations. Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan. **Do not bill MAA.** Contact the plan by calling the telephone number indicated on the client’s Medical ID card.

Primary Care Case Manager (PCCM)/Management Clients

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be “PCCM.” These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a plan setting. Please refer to the client’s DSHS Medical ID card for the PCCM.

Dually-Enrolled Clients

Dually-enrolled (Medicare-Medicaid) clients and **Medicare only** clients may be eligible to receive certain home and community based services under the Community Options Program Entry System (COPES) or Title XIX Personal Care programs. These programs are administered under the Aging and Adult Services Administration (AASA). Please contact your local AASA field office for more information on these programs. If you do not know the local telephone number, you may call:

**State Reception Line
1-800-422-3263**

Coverage/Limits

When does MAA reimburse for covered home health services? [Refer to WAC 388-551-2030]

MAA reimburses for covered home health services provided to eligible clients when all of the criteria listed in this section are met. Reimbursement is subject to the restrictions or limitations in this billing instruction and other applicable published Washington Administrative Codes (WAC).

Home health skilled services provided to eligible clients must:

- Meet the definition of “acute care”;
- Provide for the treatment of an illness, injury, or disability;
- Be medically necessary (see Definitions);
- Be reasonable, based on community standard of care, in amount, duration, and frequency;
- Be provided under a Plan of Care (POC). Any statement in the POC must be supported by documentation in the client’s medical records;
- Be used to prevent placement in a more restrictive setting;

In addition, the client’s medical records must justify the medical reason(s) that the services should be provided in the client’s residence instead of a physician’s office, clinic, or other outpatient setting. This includes justification for services for a client’s medical condition that requires teaching that would be most effectively accomplished in the client’s home on a short-term basis.

- Be provided in the client’s residence. MAA does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client’s place of residence.
 - ✓ **Residential facilities** contracted with the state to provide limited skilled nursing services are **not reimbursed** separately for those same services under MAA’s Home Health program.
 - ✓ It is the home health agencies responsibility to request coverage for a client when the services are not available to the client in the community or through LTC.
 - ✓ If the client meets the criteria in these billing instructions for therapy services, MAA will evaluate the need after receiving the request (see D.9).
 - ✓ Refer to Aging and Adult Services Administration’s Residential Services web page: <http://www.aasa.dshs.wa.gov/Lookup/BHRequestv2.asp>

- Be provided by a home health agency that is Title XVIII (Medicare) certified and state-licensed.


Refer to WAC 388-551-2100(1)

MAA covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165.

What is covered?

Acute Nursing

[Refer to WAC 388-551-2100(2)(3)]

1. MAA covers the following home health acute care skilled nursing services:
 - a. **Full Skilled Nursing Services** - that require the skills of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of a Registered Nurse, if the services involve one or more of the following:
 - Observation (approximately 3 weeks);
 - Assessment (approximately 3 weeks);
 - Treatment;
 - Teaching (approximately 3 days);
 - Training (approximately 4 visits unless client remains unstable); and
 - Management; and
 - Evaluation.
 - b. **Brief Skilled Nursing Visit** - only if one of the following activities is performed during the visit:
 - An injection;
 - Blood draw; or
 - Placement of medications in containers (e.g., envelopes, cups, medisets).
-  **Note:** Use revenue code 580 when billing for a brief skilled nursing visit.

MAA limits skilled nursing visits provided to eligible clients to two (whether they are brief or full) per day.

c. **Home Infusion Therapy** - only if the client:

- Is willing and capable of learning and managing the client's infusion care; **or**
- Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.



Note: MAA does not reimburse administration of IV therapy through the Home Health program. MAA does reimburse for the teaching of IV therapy and skilled observation of IV site through the Home Health program.



Note: All other infusion therapy related services must be billed on a HCFA-1500 claim form using the Infusion Therapy Billing Instructions (see Important Contacts).

Note:

Although DSHS clients may have a paid caregiver who is willing and capable of performing the skilled task, as a paid caregiver they may not be paid for this service. The client may want to be involved in self-directed care [Refer to WAC 388-71-0580].

d. **Infant Phototherapy** – for an infant diagnosed with hyperbilirubinemia:

- When provided by an **MAA-approved*** infant phototherapy agency; **and**
- For up to **five (5)** skilled nursing visits per infant.



Note: If the infant's mother is enrolled in an MAA managed care plan at the time of the birth, you must receive approval from the managed care plan listed on the mother's DSHS Medical ID card. **Do not bill MAA for these services.**

Additional Information Required in the Plan of Care

(See page E1 and E2 for a complete list):

- Infant's name, **mother's** name, and PIC(s);
- Information regarding the infant's medical condition, and the family's ability to safely provide home phototherapy;
- Name of hospital where infant was born and discharge date;
- Visit notes that include family teaching and interventions; **and**
- Bilirubin levels

***How do I become an MAA-approved infant phototherapy agency?**

- Be a Medicaid and Medicare certified Home Health agency;
- Have an established phototherapy program; and
- Submit to MAA for review, all of the following:
 - ✓ Six months of documented phototherapy services delivered for infants;
 - ✓ A written policy for home phototherapy submitted to MAA for review that includes guidelines, procedures, and job descriptions verifying experience in pediatrics and maternal child health; **and**
 - ✓ Three letters of recommendation from pediatricians who have utilized your program.



Note: MAA will not cover infant phototherapy, unless your agency has a pre-approval letter on file from MAA noting that you are an MAA-approved infant phototherapy agency. Refer to MAA's Durable Medical Supplies & Equipment Billing Instructions for equipment component.

e. **Limited High-Risk Obstetrical Services:**

- For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;
- For up to **three** home health visits per pregnancy, if:
 - ✓ Enrollment in or referral to the following providers of First Steps has been verified:
 - Maternity Support Services (MSS); **or**
 - Maternity Case Management (MCM); **and**
 - ✓ The visits are provided by a registered nurse who has either:
 - National perinatal certification; **or**
 - A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.



Note: Use revenue code **551** with diagnosis codes V23 or 630 through 670 when billing for skilled high-risk obstetrical nursing care visits in the home setting.

MAA does not reimburse for high-risk obstetrics if the registered nurse has not met the criteria listed above.

See Section F - MAA's Specific Criteria for High-Risk Obstetrical

Specialized Therapy

[Refer to WAC 388-551-2110(1)(2)]

Specialized therapy services includes: physical, occupational, or speech/audiology services. MAA reimburses for specialized therapy services only when the client is **not able to access these services in their local community**. MAA limits specialized therapy visits to one per client, per day, per type of specialized therapy. Documentation must justify the skilled need of the visit.

Under specialized therapy, a client's residence may include a residential care facility with skilled nursing services available.



Note: The maximum number of visits allowed is based on appropriate medical justification. MAA does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s). If the client requires more than one therapist in the residence on the same day, MAA requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Home Health Aide Services

[Refer to WAC 388-551-2120(1)(2)(3)]

1. MAA limits home health aide visits to **one per day**.
2. MAA reimburses for home health aide services only when the services are provided under the supervision of, and in conjunction with practitioners who provide:
 - a. Skilled nursing services; or
 - b. Specialized therapy services.
3. MAA covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every 14 days to monitor or supervise home health aide services, with or without the presence of the home health aide. MAA does not reimburse for services covered by another state administration such as LTC services, COPES, CHORE, or CAP services.



Note: Contact the client's DSHS case manager/case resource manager to see if the client is eligible for, or is already receiving, LTC services, COPES, CHORE, or CAP services.

4. Documentation in the client's file must justify the need for the home health aide visits.

What is not covered? [Refer to WAC 388-551-2130]

MAA does not cover the following home health services under the Home Health program, unless otherwise specified:

1. Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the Department of Social and Health Services, Aging and Adult Services Administration (AASA) or Division of Developmental Disabilities (DDD).
 - i. **MAA may consider requests** for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for AASA or DDD to implement a long-term care skilled nursing plan or specialized therapy plan; and
 - ii. On a case-by-case basis, MAA may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until an AASA or DDD long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this billing instruction and other published WACs. (Refer to page D.9.)

Home Health Agencies

- The client must have a stable, chronic skilled nursing need.
- The client's skilled nursing need cannot be met in the community (e.g., the client is unable to access outpatient services in the community);
- The home health provider must **contact MAA and request coverage** through the home health program (refer to page D.9);

MAA will first contact the client's AASA or DDD case manager to see if long-term care skilled nursing services are accessible in the community or through AASA or DDD.

If there are no other options, MAA will send a notification letter to the client, Home Health agency, and case manager notifying them that the chronic, long-term care skilled nursing visits will be reimbursed through MAA for a limited time until a long-term care plan is in place.



See LTC Skilled Nursing Needs flow chart on next page...

What is not covered? (cont.)

2. Social work services;
3. Psychiatric skilled nursing services;
4. Pre- and postnatal skilled nursing services, except those listed on page D4;
5. Well-baby follow-up care;
6. Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing available (refer to page D.9);
7. Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services;
8. Home health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change, unless the client meets the applicable criteria on page D.1);
9. Home health specialized therapies and home health aide visits for clients in the following programs:
 - a. CNP – emergency medical only; and
 - b. LCP-MNP – emergency medical only.
10. Skilled nursing visits for a client when a home health agency cannot **safely** meet the medical needs of that client within home health services program limitations;

Examples:

- a. The client or caregiver is not willing and/or capable of managing the client's infusion therapy care; or
 - b. A client requires daily visits in excess of program limitations.
11. More than one of the same type of specialized therapy and/or home health aide visit per day. **MAA does not reimburse for duplicate services** for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).
12. Any home health services covered by another state administration such as LTC services, COPES, CHORE, or CAP services.

13. Home health visits made without a written physician order, unless the verbal order is:
- a. Documented prior to the visit; and
 - b. The document is signed by the physician within 45 days of the order being given.

MAA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

MAA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0165.

Requests must include the following:

1. Name of agency and provider number;
2. Client's name and PIC number;
3. Copy of the plan of care; and
4. Explanation of client-specific medical necessity.

Send requests for noncovered services to:

Medical Assistance Administration
Division of Medical Management
Home Health Program Manager
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

See next page for information regarding Limitation Extensions.

Authorization

MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services **beyond** those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165.

Limitation Extension

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide **more units of service** than allowed in MAA's Washington Administrative Code (WAC) and billing instructions.

How do I get LE authorization?

LE authorization may be obtained by using the written/fax authorization process. See address and fax number below.

Your request must include the following:

5. Name of agency and provider number;
6. Client's name and PIC number;
7. Copy of the plan of care; and
8. Explanation of client-specific medical necessity to exceed limitation.

How do I obtain written/fax authorization?

Authorization may be obtained by sending a request, along with any required forms, to:

Medical Assistance Administration
Division of Medical Management
Home Health Program Manager
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-2262

Provider Requirements

Requirements for home health providers

[Refer to WAC 388-551-2210]

See WAC 388-502-0020 for General Provider Requirements.

For any delivered home health service to be payable, MAA requires home health providers to develop and implement an individualized plan of care (POC) for the client.



Note: Home health providers are required to comply with audits and/or site visits which are done to ensure quality of care and compliance with state rule. (Selection for site visits is routine and does not imply that the department noted a problem.) Refer to page G.1 for further information.

About the Plan of Care

The POC must:

- Be documented in writing and be located in the client's home health medical record;
- Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;
- Reflect the physician's orders and client's **current** health status;
- Contain specific goals and treatment plans;
- Be reviewed and revised by the licensed registered nurse or licensed therapist and the client's physician at least every 60 calendar days;
- Signed by the physician within 45 days of the verbal order;
- Returned to the home health agency's file; and
- Be available to department staff or its designated contractor(s) on request.

What must be included in the Plan of Care?

The provider must include in the POC all of the following:

- The client's name and date of birth;
- The start of care;
- The date(s) of service;
- The primary diagnosis (the diagnosis that is **most related to the reason** the client qualifies for home health services) and is the reason for the visit frequency;
- All secondary medical diagnosis including date(s) of onset (**O**) or exacerbation (**E**);
- The prognosis;
- The type(s) of equipment required;
Note: Durable Medical Supplies & Equipment (MSE) must be billed on a separate HCFA-1500 claim form using the DME provider number assigned by MAA. Do not bill Durable MSEs on a Home Health claim.
- A description of each planned service and goals related to the services provided;
- Specific procedures and modalities;
- A description of the client's mental status;
- A description of the client's rehabilitation potential;
- A list of permitted activities;
- A list of safety measures taken on behalf of the client; and
- A list of medications which indicates:
 - ✓ Any new (**N**) prescription; and
 - ✓ Which medications are changed (**C**) for dosage or route of administration.

During your review period, the following is important information to send with your plan of care if not already included:

The provider must include in, or attach to the POC:

- Client's address including name of the residential care facility the client is residing in (if applicable).
- A description of the client's functional limits and the effects;
- Documentation that justifies why the medical services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting;
- Significant clinical findings;
- Dates of recent hospitalization;
- Notification to the DSHS case manager of admittance; and
- A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge.
- A short summary of what is happening with the client or what has happened since last review.

Documentation that must be kept in the client's medical record but does NOT have to be sent to MAA

The individual client medical record must comply with community standards of practice, and must include documentation of:

- Visit notes for every billed visit;
- Supervisory visits for home health aide services as described on page D.6, #3;
- All medications administered and treatments provided;
- All physician orders, new orders, and change orders, with notation that the order was received prior to treatment;
- Signed physician new orders and change orders;
- Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;
- Interdisciplinary and multidisciplinary team communications;
- Inter-agency and intra-agency referrals;
- Medical tests and results;
- Pertinent medical history; and
- Notations and charting with signature and title of writer.

What documentation must be kept in the visit notes?

The provider must document at least the following in the client's medical record:

- Skilled interventions per the POC;
- Client response to POC;
- Any clinical change in the client status;
- Follow-up interventions specific to a change in status with significant clinical findings; and
- Any communications with the attending physician.

In addition, when appropriate:

- Any teachings, assessment, management, evaluation, client compliance, and client response;
- **Weekly** documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;
- If a client's wound is not healing, the client's physician has been notified, the client's wound management program has been appropriately altered, and; if possible, the client has been referred to a wound care specialist; and
- The client's physical system assessment as identified in the POC.

Insufficiently documented home health care service

[Refer to WAC 388-551-2220(6)]

MAA may take back or deny payment for any insufficiently documented home health care service when the MAA Medical Director or designee determines that:

- The service did not meet the conditions listed in the Coverage/Limitation section; or
- The service was not in compliance with program policy.

Criteria for High-Risk Obstetrical

Hyperemesis Gravidarum

GOALS:

1. Assess the client's condition;
2. Teach the client to help maintain her pregnancy to term; **and**
3. Reduce the signs and symptoms of fluid, nutritional and electrolyte imbalances.

Home care for the client with hyperemesis gravidarum (HG) may be initiated when weight loss and significant metabolic changes require fluid and nutritional replacement therapy that can be managed in the home setting. The client or caregiver must be willing and capable of learning and managing the client's intravenous therapy.

Therapeutic Skilled Nursing Services may be initiated with the obstetrical provider's request for care. These services are designed to reinforce the clinic, hospital and/or provider's teaching. The nursing services assist the client and family in managing her care in the home and may include:

- Education about the factors that may contribute to hyperemesis gravidarum, such as stress and coping with pregnancy;
- Education on the symptoms related to dehydration and electrolyte disturbances and their effects on the mother and fetus (e.g., parenteral fluids and nutritional supplements);
- Assurance that the client is able to follow the treatment regimen (parenteral fluids and nutritional supplements) and comply with medications (antiemetics);
- Reinforcement of the obstetrical provider's plan of care, including the plan for resuming oral intake;
- Demonstration of the ability to manage and administer the infusion treatment ordered by the obstetrical provider (hydration or total parenteral nutrition); **and**
- Education concerning when to notify the obstetrical provider.

Documentation in the client record must include, but is not limited to, the following:

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of hyperemesis gravidarum (HG)
- Evaluation of clinical status of mother and fetus, including maternal weight and vital signs;
- Evaluation of the obstetrical provider's plan of care;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family regarding management of the prescribed care for a medically high-risk pregnancy.

Gestational Diabetes

GOALS:

1. Assess the client's condition;
2. Provide adequate support and education to help the client reduce symptoms of gestational diabetes; **and**
3. Maintain the pregnancy to planned delivery.

Whenever possible, education should be given at suitable diabetic teaching centers. A more complete and comprehensive training is available at these sites. A few cases may merit skilled nursing services. For example, skilled nursing may be provided to a client who is unable to get to a diabetic educational center or to a client who has special learning needs.

Therapeutic Skilled Nursing Services may be initiated when there is a documented reason for teaching gestational diabetes management in the home. It should reinforce the obstetrical provider's or clinic's teaching.

Therapeutic skilled nursing services may include:

- Assuring the client understands her plan of care;
- Managing insulin injections;
- Diet and exercise;
- Demonstrating and teaching the blood glucose monitoring techniques, and the necessary times to test and documentation of testing results;
- Explaining the differences between normal and abnormal blood glucose test results;
- Explaining protocols for results of abnormal blood glucose, ketones and protein in the urine;
- Planning with the client for emergency treatment of hyper/hypoglycemia; **and**
- Explaining when to notify the obstetrical provider about symptoms.

Documentation in the client record must include, but is not limited to, the following:

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of gestational diabetes;
- Evaluation of clinical status of mother and fetus;
- Evaluation of obstetrical provider's Plan of Care;
- Rationale for in-home gestational diabetes education;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family in the management of the prescribed treatment for a medically high-risk pregnancy.

Preterm Labor

GOALS:

1. Assess the client's condition; **and**
2. Provide adequate support and education to help the client maintain her pregnancy to term.

Home care for preterm labor (PTL) symptoms may be initiated with the obstetrical provider's prescription for care and when there is an assurance of a viable newborn.

Preventive Services may be initiated between 20-25 weeks when an eligible client has a history of preterm births and/or has a multiple gestation and has been started on oral tocolytics.

Therapeutic Skilled Nursing Services may be initiated between 25-36 weeks gestation or birth (whichever comes first) or until the tocolytics are discontinued. Cervical changes should be documented at the start of care.

Skilled nursing care reinforces the medical protocol and assures that:

- The client comprehends and is compliant with the medication;
- The client can manage the restricted activity plan;
- The plan of care is coordinated with Maternity Support Services so that childcare and transportation services are readily available, if needed; **and**
- The client education includes fetal movement count, signs and symptoms of preterm labor and when to notify obstetrical provider.

Documentation in the client record must include, but is not limited to, the following:

- Estimated date of confinement;
- Gravidity/parity;
- History of pre-term labor (PTL);
- Documented cervical change;
- Obstetrical provider's plan for care;
- Assessment of maternal and fetal clinical status;
- Medications;
- Referral to a Maternity Support Service (MSS) provider; **and**
- Education of the client and family in management of the prescribed care for a high-risk pregnancy.

Pregnancy-Induced Hypertension

GOALS:

1. Assess the client's condition;
2. Provide adequate support and education to help the client reduce symptoms of pregnancy induced hypertension; **and**
3. Maintain the pregnancy to term.

Home care for Pregnancy-Induced Hypertension (PIH) may be initiated after 20 weeks gestation when:

- Blood pressure readings have increased by 30 mm Hg (systolic pressure)/15 mm Hg (diastolic pressure) over the baseline; **and**
- The client has accompanying symptoms (e.g., lab changes, proteinuria, and a weight gain greater than two lbs./week). Late signs/symptoms may include hyperreflexia, epigastric pain and/or visual changes.

Therapeutic Skilled Nursing Services may be initiated at the prescribing medical provider's request and documented signs and symptoms indicate the PIH may be safely managed in the home setting **and** the:

- Client requires bed rest with bathroom privileges.
- Client understands and is able to comply with bed rest/reduced activities in the home.
- Assessment includes vital signs, fetal heart tones, fundal height, deep tendon reflexes, and a check for proteinuria, edema and signs and symptoms of PIH.
- Client and family members receive education on:
 - ✓ How to monitor blood pressure;
 - ✓ How to evaluate urine for protein; **and**
 - ✓ When to notify the obstetrical provider.
- Reinforce education client received from her obstetrical provider's office. This may include:
 - ✓ Etiology and diagnosis of PIH;
 - ✓ Treatment and rationale;
 - ✓ Nutrition needs;
 - ✓ Need for rest;
 - ✓ Client monitoring of uterine and fetal activity; **and**
 - ✓ The role of medication in reducing symptoms (if provided).
- The plan of care is coordinated with the MSS provider so that childcare and transportation services are readily available.

Documentation in the client record must include but is not limited to the following:

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of PIH;
- Evaluation of clinical status of mother and fetus;
- Obstetrical provider's plan for care;
- Frequency of clinic visits;
- Activity level;
- Medication, if prescribed;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family on management of the prescribed care.

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Review Period

Home Health Billing Procedure During Review Period

- MAA home health agency providers are divided into 1 of 4 quarters for review (see page G.2).
 - ✓ Each agency is assigned to a quarter.
 - ✓ Each quarter is 3-months long.
 - ✓ Each agency will remain within the designated quarter until notified by MAA or your main office address changes to a different county.



See Chart of Counties by Quarter on next page to determine your agency's review period.

- MAA will review **ALL claims** submitted during your three-month review period.



Note: MAA reviews all claims received in our office during your 3-month review period regardless of the dates of service.

- MAA's Home Health Program Manager may arrange a site visit to your agency. You will be notified if a visit is scheduled.



Note: Selection for a site visit does not mean we have discovered a problem with your agency. This visit will be an opportunity for agency staff and MAA's Home Health Program Manager to meet and share ideas. Agency-specific findings, particular to program compliance, billing practices, and quality of care issues, will also be discussed.

- During your review period, you must submit to MAA all supporting medical justification and documentation (usually 5 pages or less) for review as outlined in this billing instruction (pages E.1-E.3). Call (360) 725-1676, if you have a question. [WAC 388-551-2220(4)]
- During your review period, at least one week prior to billing electronically, send your medical justification and documentation to:

**Quality Fee-For-Service
Home Health Program Manager
PO Box 45506
Olympia WA 98504-5506**

This is not a billing address!

Chart of Counties by Quarter

MAA assigns each Home Health agency to a quarter based on the address of their main office.

If your agency moves the main office to a different county, notify MAA's Home Health Program Manager immediately as your review quarter may change.

<p>1st Quarter November through January</p> <p>Clallam Mason Clark Pacific Cowlitz Skamania Grays Harbor Thurston Jefferson Wahkiakum Kitsap Idaho Lewis Oregon</p>	<p>2nd Quarter February through April</p> <p>Adams Kittitas Asotin Klickitat Benton Pend Oreille Chalan Spokane Columbia Stevens Franklin Walla Walla Garfield Whitman Grant Yakima</p>
<p>3rd Quarter May through July</p> <p>Douglas San Juan Ferry Skagit Island Snohomish Okanogan Whatcom Pierce</p>	<p>4th Quarter August through October</p> <p>King</p>



Note: Each three month review period begins the first day of the 1st month and ends the last day of the 3rd month. All claims that reach MAA's Claims Processing unit during your review period are reviewed. MAA denies claims if the supporting medical justification does not reach MAA's Home Health Program Manager in time for the review. You will need to rebill.

Electronic billers need to send the POC at least one week prior to billing electronically to prevent the need to rebill.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

- ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders MAA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.




Note: If MAA has recouped a managed care plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

Medicare Crossover Claims: If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim. If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim.

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- ✓ **MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:**
 - DSHS certification of a client for a retroactive² period; or
 - The provider proves to MAA's satisfaction that there are other extenuating circumstances.
 - ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.
 - **Resubmitted Claims**
 - ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.
-  **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above. When rebilling, send a copy of the original Remittance and Status Report along with the claim. Be sure to cross out any lines that have already been paid.
- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
 - The provider, or any agent of the provider, **must not bill a client or a client's estate** when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ MAA does not pay the claim.

² **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

What fee should I bill MAA?

Bill MAA your *usual and customary fee* (the fee you bill the general public). MAA's payment will be either your usual and customary fee or MAA's maximum allowable rate, whichever is less.

When can I bill the client?

Please refer to MAA's General Information Booklet for information on billing the client or to WAC 388-502-0160.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in form locator 83 on the UB-92 claim form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator 83 when you bill MAA, the claim will be denied.

<p>Note: Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborn.</p>

Third party liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID card. An insurance carrier's time limit for claim submissions may be different than MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA; and
- Attach the insurance carrier's statement.

If you are rebilling, also attach a copy of the *MAA Remittance and Status Report* showing the previous denial.

If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the **Comments** field of the Electronic Media Claim (EMC).

Third-party carrier codes are available via the Internet at <http://maa.dshs.wa.gov> or by calling the Coordination of Benefits Section at 1-800-562-6136.

Common Explanation of Benefits (EOB) Denial Codes for the Home Health Program

The Remittance and Status Report (RA) you receive back in the mail may list one or more of the following EOB codes.

EOB Code	Explanation of EOB Code
041	Duplicate of claim or service previously paid. Also, used if twice a day visits have been billed and there are no orders to cover the second visit.
043	Sent to MAA's Home Health Program Manager Do not rebill.
061	Bill Medicare A. If not Medicare eligible, submit justification to Home Health Program Manager and rebill.
068	Bill Medicare B. If not Medicare eligible, submit justification to Home Health Program Manager and rebill.
370	Services do not meet the Medicaid Home Health criteria. If you have supporting justification, submit documentation to the Home Health Program Manager and rebill.
373	Medical review by MAA. Call MAA's Home Health Program Manager at (360) 725-1676.
385	Your Plan of Care was received, however updated M.D. orders/clinical notes are needed to justify treatment. Example: One wound assessment needed for each month wound care is billed or documentation of reason home health is needed.
506	Telephone confirmation Claim or line item has been corrected.
591	Visits billed exceed plan of care. Submit physician change orders to cover the visits to the Home Health Program Manager and rebill.
592	No (current) plan of care on file. Please submit a plan of care to the Home Health Program Manager and rebill.

Medical Review Rebilling:

- ◆ Prior to rebilling, please cross off all lines on the claim form that MAA has already paid.
- ◆ During your review period, if you receive a denial for payment and you have the supporting documentation, follow the criteria in Section E, then send the bill and appropriate documentation to:

ATTN: Special Handle
Home Health Program Manager
PO Box 45506
Olympia, WA 98504-5506

Fee Schedule

The following rates are established for the two regional classifications of home health agencies: Metropolitan Statistical Area (MSA) and Non-Metropolitan Statistical Area (Non-MSA). The rates are as follows:

July 1, 2003

	Skilled Nursing Intervention/ Skilled, High-Risk Obstetrical Nursing	Brief Nursing Visit	Physical Therapy	Speech Therapy	Occupational Therapy	Home Health Aide
Revenue Code:	0551	0580	0421	0441	0431	0571
METROPOLITAN STATISTICAL AREA – RATES PER VISIT						
Bellingham	\$87.40	\$19.20	\$78.99	\$85.79	\$81.34	\$47.89
Bremerton/ Kitsap	77.14	19.20	69.71	75.71	71.85	42.29
Olympia	83.16	19.20	75.17	81.63	77.42	45.58
Richland/ Kennewick	79.87	19.20	72.21	78.41	74.37	43.82
Seattle/ Everett	88.07	19.20	79.60	86.44	81.96	48.25
Spokane	87.83	19.20	79.49	86.33	81.85	48.20
Tacoma	84.81	19.20	76.65	83.26	78.94	46.49
Vancouver	88.24	19.20	80.04	86.94	82.41	48.54
Yakima	80.70	19.20	72.89	79.23	75.14	44.22
NON-METROPOLITAN STATISTICAL AREA – RATES PER VISIT						
Non-MSA	\$87.73	\$19.20	\$82.36	\$89.11	\$90.16	\$42.22

* Home health agency providers may receive reimbursement for administering flu vaccine injections to appropriate MAA clients at sites such as senior and neighborhood centers. **On-line fix 11-03-04**

NOTE:

These rates are the most current rates and are effective for dates of service on and after July 1, 2003.

How to Complete the UB-92 Claim Form

The numbered boxes on the UB-92 are called **form locators**. *Only form locators that pertain to MAA are addressed here.* If you are billing electronically, use claim type **"P" - Medical Vendor**.

Send your hard copy claim to:

Division of Program Support
PO Box 9246
Olympia WA 98507-9246

Send magnetic tapes/floppy disks to:

Division of Program Support – Claims Control
PO Box 45560
Olympia, WA 98504-5560

FORM LOCATOR, DESCRIPTOR AND INSTRUCTIONS:

- | | |
|--|--|
| <p>1. <u>Provider Name, Address & Telephone Number</u> - Enter the provider name, address, and telephone number as filed with the Division of Program Support (DPS).</p> <p>3. <u>Patient Control Number</u> - Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading <i>Patient Control Number</i>.</p> <p>4. <u>Type of Bill</u> - Enter 33 plus one of the following as the third digit:
 1 = Admit through discharge
 2 = Interim, first claim
 3 = Interim, continuing claim
 4 = Interim, last claim</p> <p>6. <u>Statement Covers Period</u></p> <p> A. Enter the beginning and ending service dates for the period included on this bill.</p> <p> B. For all services received on a single day, enter the date in both the "from" and "through" areas.</p> | <p>12. <u>Patient Name</u> - Enter the client's last name, first name, and middle initial as shown on his/her DSHS Medical Identification card.</p> <p>13. <u>Patient Address</u> - Enter the client's address.</p> <p>14. <u>Birthdate</u> - Enter the client's birthdate.</p> <p>17. <u>Admission Date</u> - Enter the date services began (MMDDYY).</p> <p>24. <u>Condition Codes</u> - Enter the appropriate code from this list:</p> <p><u>Insurance Codes</u></p> <p>01 = Military service related condition
 02 = Employment related condition
 03 = Patient covered by insurance not reflected here
 04 = Lien has been filed</p> |
|--|--|

42. **Revenue Code** - Enter the appropriate revenue code(s) from the following list.

Revenue Code	Description
421	Physical Therapy
431	Occupational Therapy
441	Speech Therapy
551	Skilled nursing intervention (includes high risk obstetrical)
571	Home Health Aide
580	Brief nursing visit

43. **Description** - Enter a narrative description of the detailed revenue categories by date of service. For more efficient and accurate processing, you must follow the steps below:

- A. When billing a span of dates, only consecutive days may be billed on a single line entry.
- B. When billing non-consecutive days, only two dates of service may be billed per line.
- C. When **multiple** services are performed on the **same day**, the second service must be billed on a **separate line**. If there are two items within the same line, both of the items will be denied.
- D. A maximum of 21 lines is allowed per claim.

46. **Service Units** - Enter the appropriate units or days.

47. **Total Charges** - Enter the charge for each line. After all line charges, enter the total of all charges.

50. **Payer Identification** - Enter name of insurer(s) *if* other health insurance benefits are available.

51. **Medicaid Provider Number** - Enter

the provider number issued to you by DPS. This is the seven-digit provider number that appears on your Remittance and Status Report.

54. **Prior Payments** - Enter the amount due or received from other insurance.

55. **Estimated Amount Due** - Total charges *minus* any amount(s) entered in form locator(s) 48 and 54 (*other insurance*).

58. **Insured's Name** - If other insurance benefits are available and coverage is under another name, enter the *insured's* name here.

59. **Patient's Relationship To Insured** - Enter one of the following two-digit codes indicating the relationship of the client to the identified insured:

- 01 = Patient is insured
- 02 = Spouse
- 03 = Natural child/insured has financial responsibility
- 04 = Natural child/insured does not have financial responsibility
- 05 = Step child
- 06 = Foster child
- 07 = Ward of court/patient ward of insured
- 08 = Employee/patient employed by insured
- 09 = Unknown
- 10 = Handicapped dependent
- 11 = Organ donor
- 12 = Cadaver donor
- 13 = Grandchild
- 14 = Niece/nephew
- 15 = Injured plaintiff/patient claiming insurance as result of injury covered by insured
- 16 = Sponsored dependent
- 17 = Minor dependent of minor dependent
- 18 = Parent
- 19 = Grandparent

60. Insured's ID No. - Enter the **PIC** (Patient Identification Code). This information is obtained from the client's current monthly Medical ID card. It is an alphanumeric code assigned to each MAA client and consists of the client's:

- a) First and middle initials (*or* a dash (-) if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name (and spaces if the name is fewer than five letters).
- d) Alpha or numeric character (tiebreaker).

For example:

- 1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- 2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
- 3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB Baby on Parent's PIC.

Note: The client's DSHS Medical ID card is your proof of eligibility. Use the PIC code of either parent if a newborn has not been issued a PIC, and enter indicator **B** in form locator 84.

61. Insurance Group Name - If other insurance benefits are available, enter the *name of the insurance group or plan* under which the insured is covered.

62. (Insurance) Group Number - If other insurance benefits are available, enter any identification number identifying the *group* through which the individual is insured.

65. Employer Name - If other insurance benefits are available through employment, enter the employer's name.

67. Principal Diagnosis Code Enter the ICD-9-CM diagnosis code describing the client's principal diagnosis, the diagnosis most related to the reason for Home Health.

68-75. Other Diagnosis Codes - Enter any ICD-9-CM diagnosis codes indicating conditions *other than* the principal condition.

82. Attending Physician ID - Enter the seven-digit provider identification number.

83. Physician ID - If the client is under PCCM, the referring PCCM provider number must be used.

84. Remarks - Enter a narrative description of the condition chiefly responsible for requiring home health services.

Note: When applicable, enter indicator B in right side of this locator.

HOME HEALTH AGENCY 123 MAIN STREET ANYTOWN WA 99999				2		3 PATIENT CONTROL NO. BB112233						333
5 FEO. TAX NO.				8 STATEMENT COVER PERIOD 10/1/02 10/31/02		7 CUY D.		9 HCD D.		10 CH D.		11
12 PATIENT NAME DOE, JOHN A				13 PATIENT ADDRESS 500 HOME STREET, ANYTOWN WA 99999								
14 BIRTH DATE 03/20/40		15 SEX M		16 MO 9		17 DATE 15/02		18 ADJUDICATED 10/1/02 10/31/02		19 TYPE 1		20
21 CH H		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27
28 CODE		29 OCCURRENCE DATE		30 OCCURRENCE DATE		31 CODE		32 OCCURRENCE DATE		33		34
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